NURSING FACILITY

SCHEDULE J-TAX

For the Month of _____ 1993

Provider Name _____

Provider Number _____

	Revenue	Tax
Certified NF Beds*	_____	_____
All Other Taxed Beds*	_____	_____
Total Per Provider Tax Forms Submitted To Revenue Cabinet	_____	_____

*Revenue and Tax must be directly costed to certified NF beds. Revenue and Tax must include amounts for ancillaries.

TN# 93-14
Supersedes
TN# None

Approval Date NOV

Effective Date 7-1-93